STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035103	A. BUILDING _____ B. WING _____	**10/03/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CITADEL POST ACUTE	**5121 EAST BROADWAY ROAD MESA, AZ 85206**

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F 0554 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow residents to self-administer drugs if determined clinically appropriate.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, interviews and policy review, the facility failed to ensure that one resident (#196) was assessed to determine clinical appropriateness to self administer medications. The deficient practice could result in medications not being taken as ordered, possible complications as a result of an inability to follow directions and unsafe storage of medications. The facility census was 103 residents. Findings include: Resident #196 was admitted to the facility on (MONTH) 19, 2019, with [DIAGNOSES REDACTED]. A care plan dated (MONTH) 19, 2019 included the resident was at risk for impaired thought processes related to end stage liver disease. The goal was for the resident to maintain the current level of cognitive function. Interventions included to face the resident when speaking, reduce distractions, use simple directive sentences, and provide the resident with necessary cues. Review of the admission Minimum Data Set assessment dated (MONTH) 26, 2019, revealed a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. An observation was conducted on (MONTH) 30, 2019 at 9:30 a.m., of the resident in her room. At this time, a small cup containing four pills was observed on the resident's bedside table. The resident stated that she was planning on taking the pills soon, but had not gotten around to it yet. Review of the physician's orders [REDACTED]. Review of the clinical record revealed no evidence that an assessment for self administration of medications was completed. An interview was conducted with a registered nurse (RN/staff #27) on (MONTH) 1, 2019 at 12:26 p.m. He said in order for a resident to self-administer medication, an assessment for safety would need to be completed, and there needs to be a physician's orders [REDACTED]. An interview was conducted with a RN (staff #110) on (MONTH) 1, 2019 at 12:40 p.m. She said there would need to be a physician's orders [REDACTED]. She said the resident would need to be observed for safety of self administration, and there would need to be some type of secure storage in the resident's room, if the resident planned to keep the medications at the bedside. An interview was conducted on (MONTH) 1, 2019 at 2:08 p.m., with the Director of Nursing (DON/staff #171). She said if a resident wanted to self administer medication, they would need a physician's orders [REDACTED]. She said the resident would receive education and would provide a demonstration of how to self-administer, as well as when to administer and have an understanding of side effects and risks and/or benefits. She said the medications could be stored at the bedside with a lockbox and a key in the resident's possession. During a follow-up interview at 2:39 p.m. on (MONTH) 1, 2019, staff #171 stated her expectation is that when nurses administer medications to residents, they will observe the residents actually taking the medications. Review of the facility's policy for self administration of medications revealed that if a resident wished to self administer medication, the interdisciplinary team would assess and periodically re-evaluate the resident based on change in the resident's status. The resident's cognitive, communication, visual, and physical ability to carry out this responsibility would be evaluated. If a resident was a candidate for self administration of medications, this would be indicated in the chart. The resident would receive instruction from the nurse regarding proper administration of medication.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record reviews, staff interviews and policy review, the facility failed to ensure that the Minimum Data Set (MDS) assessment accurately reflected the status of 2 residents (#3 and #76). The deficient practice could affect continuity of care. The census was 103 residents. Findings include: -Resident #3 was admitted to the facility on (MONTH) 21, (YEAR), with [DIAGNOSES REDACTED]. A care plan included the resident had a [MEDICATION NAME] and used a Foley urinary drainage bag overnight. Review of the quarterly MDS assessment dated (MONTH) 24, 2019, revealed documentation that the resident had an indwelling catheter and an ostomy. However, during an observation of the resident on (MONTH) 1, 2019 at 10:17 a.m., the resident was observed to have a [MEDICATION NAME], but did not have an indwelling catheter. An interview was conducted with the MDS coordinator (staff #41) on (MONTH) 1, 2019 at 10:26 a.m. She stated that to code the portion of the MDS assessment that referred to indwelling catheters and ostomies, she would review the nurse aide documentation, nursing notes, physician's orders [REDACTED]. She said the documentation on the MDS assessment for an indwelling catheter was a mistake, because resident #3 only had a [MEDICATION NAME]. -Resident #76 was admitted to the facility on (MONTH) 23, (YEAR), with [DIAGNOSES REDACTED]. Review of a wound assessment dated (MONTH) 15, 2019, revealed the resident had a stage 3 pressure ulcer on the right heel. The assessment stated the wound was facility acquired. However, review of the quarterly MDS assessment dated (MONTH) 20, 2019, revealed the resident had a stage 3 pressure ulcer that was present on admission. An interview was conducted with the MDS coordinator (staff #41) on (MONTH) 1, 2019 at 10:26 a.m. She said that to code the portion of the MDS assessment related to wounds, she would review physician's orders [REDACTED]. She said if a wound was present on admission, it would be documented in the wound rounds. She said the wound on the right heel of resident #76 was facility acquired. She said that she planned to file a correction for the MDS assessment for resident #76. An interview was conducted on (MONTH) 1, 2019 at 2:08 p.m., with the Director of Nursing (DON/staff #171). She said she expected that the chart would be thoroughly reviewed and any data that needed to be captured would be included in the MDS assessment. The facility's policy for accuracy of assessments stated that the MDS assessment should accurately reflect the resident's status. Each individual who completed a portion of the assessment must sign and certify accuracy of that portion of the assessment.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **Provide appropriate treatment and care according to orders, resident's preferences and goals.**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to ensure medications were administered in accordance with professional standards of practice for 1 sampled resident (#65). The deficient practice could place residents at risk for increased complications related to infections. Findings include: Resident #65 was admitted to the facility on (MONTH) 10, 2019, with [DIAGNOSES REDACTED]. A care plan dated (MONTH) 11, 2019 included the resident had an infection related to intra-abdominal abscess and is on intravenous (IV) antibiotics. An intervention was to administer antibiotic per MD orders. A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 10, 2019 revealed a score of 15 on the Brief Interview for Mental Status, which indicated the resident was cognitively intact. The MDS also noted that resident #65 was on IV antibiotics. Review of the physician orders [REDACTED]. -[MEDICATION NAME] Solution (antibiotic) 2.25 gm/50 ml, use 2.25 ml IV every 6 hours for intra-abdominal infection (administration time was midnight, 6 a.m., 12 p.m. and 6 p.m.) with a start date of (MONTH) 10, 2019 and a stop date of (MONTH) 25, 2019. -Caspofungin Acetate Solution (antibiotic) reconstituted 50 mg, use 50 mg IV one time a day for intra-abdominal infection (administration time was 5 p.m.), with a start date of (MONTH) 10, 2019 and a stop date of (MONTH) 25, 2019. -Sodium Chloride Solution (used for hydration), use 1000 ml IV every evening shift for supplement x1 liter bolus daily started on (MONTH) 11, 2019 with no stop date. Review of the (MONTH) and (MONTH) 2019 IV Medication Administration Records (MARs) for [MEDICATION NAME] revealed the following missing doses: (MONTH) 13 at 6 p.m., (MONTH) 14 at 12 p. m., (MONTH) 15 at 6 p.m., (MONTH) 17 at 12 p.m., (MONTH) 19 at 12 a.m., (MONTH) 20 at 6 p. m., (MONTH) 21 at 6 a.m., (MONTH) 22 at 6 p.m., (MONTH) 28 at 12 pm., (MONTH) 29 at 12 a. m., (MONTH) 30 at 12 a.m. and 6 a.m., (MONTH) 2 at 6 p. m., (MONTH) 3 at 6 a.m. and 6 p. m., (MONTH) 6 at 6 p. m., (MONTH) 8 at 12 a. m., (MONTH) 13 at 6 p.m., (MONTH) 15 at 12 a.m., (MONTH) 16 at 12 p.m. and 6 p.m., (MONTH) 17 at 12 a.m., 6 a.m. and at 6 p.m., (MONTH) 18, 19 and 20 at 6 p. m., (MONTH) 21 at 12 a.m. and 6 p.m., (MONTH) 22 at 12 p.m., and (MONTH) 24 at 12 p.m. Review of the IV MARs regarding Caspofungin Acetate revealed missing doses on (MONTH) 13, 15, 20, 21 and 22, 2019 and (MONTH) 2, 3, 6, 13, 16, 17, 18, 19, 20 and 21 at 5 p.m. Review of the IV MARs regarding the sodium chloride solution revealed missing doses on (MONTH) 20, and on (MONTH) 6, 13, 17, 21 and 27. Further review of the clinical record including the nurses progress notes revealed no documentation as to why the IV medications were not administered and there was no documentation the physician was notified that the IV medications were not administered. There was also no documentation that the resident refused the IV medications. An interview was conducted with a Licensed Practical Nurse (LPN/staff #141) on (MONTH) 2, 2019 at 10:23 a.m. The LPN stated the IV MAR lists the medications that are due. She stated that when she administers medication she signs for it and if the medication is not given, she documents the reason why. She said they can't leave the MAR blank, and they have to notify the provider if any IV antibiotics are not given and should document it in the progress notes. An interview was conducted with a LPN (staff #110) on (MONTH) 2, 2019 at 10:41 a.m. The LPN stated that the IV medications which are due, will show up on the IV MAR. She stated when she administers a medication she documents it in the electronic MAR. She said if the medication is not administered, she documents that it was not given and the system will ask the reason why it was not given. She stated that she also notifies the provider if an IV medication was not given. The LPN stated that they cannot hold medication without notifying the provider. She said that she would document that the provider was notified in the IV MAR under the progress note section. Staff #110 stated they cannot leave holes in the MAR documentation regarding medications. An interview was conducted with the Director of Nursing (DON/staff #171) on (MONTH) 3, 2019 at 10:56 a.m. The DON stated that she expects the nurses to sign for medications in the IV MAR in a timely manner and if for some reason the medication is not given, they should document it in the IV MAR and the nurses progress notes. She stated the physician has to be notified and it should be documented. The DON also stated that resident #65 tends to go out of the facility in her electric wheelchair for extended hours, and in that event she expects the physician should have been notified and the IV medications should have been adjusted, so they could be administered when she came back to the facility. She stated the nurses should have documented the reason why the medications were not administered. The facility's policy for Administration of Medication included that medications shall be administered in accordance with the written orders of the attending physician. The policy included that if a medication is withheld, refused or given other than at the scheduled time, the documentation will be reflected in the clinical record. The policy also stated that the documentation should include documenting the refusal of the medication or the attempt, and any concerns.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observations, clinical record reviews, interviews and policy review, the facility failed to provide pain management according to professional standards of practice for 2 residents (#195 and #397). The deficient practice could result in residents experiencing unrelieved pain and the potential for decline. Findings include: -Resident #195 was admitted to the facility on (MONTH) 15, 2019, with [DIAGNOSES REDACTED]. A care plan was initiated on (MONTH) 15, 2019, for acute pain related to surgery [MEDICAL CONDITION]. The goal was that the resident would voice a level of comfort, with interventions to evaluate the effectiveness of pain interventions, monitor and record pain characteristics, and notify the physician if interventions were unsuccessful. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 22, 2019, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The assessment also stated the resident had received scheduled and as needed (PRN) pain medication, and that the resident experienced frequent pain. Review of the physician's orders [REDACTED]. During an interview with the resident on (MONTH) 30, 2019 at 9:00 a.m., she stated that she had waited one time for pain medication for almost 2 hours. She said at that time her pain had been around a 7 or 8 and that she had been crying. She said this had only occurred once, and normally she did not have to wait that long for pain medication. Another interview was conducted with the resident on (MONTH) 2, 2019 at 9:54 a.m. She said that she had just requested pain medication, because she was beginning to feel some discomfort. A follow up interview was conducted with the resident at 10:42 a.m. She said no one had come to address her pain yet. She said, I am doing ok, the pain is not too intense. An interview was conducted with a registered nurse (RN/staff #110) on (MONTH) 2, 2019 at 10:55 a.m. She stated that she was the nurse for resident #195. She said that she had not received any reports recently of the resident being in pain. An interview was conducted with a Certified Nursing Assistant (CNA/staff #103) on (MONTH) 2, 2019 at 10:56 a.m. She said that she was the one who had answered the resident's call light, and the resident had requested pain medication. She said she went to tell the resident's nurse, but the nurse was talking to another nurse. She said the resident had turned her call light on again, and another staff member had answered the light. She said she thought that maybe the resident had requested pain medication again and the other staff member had taken care of it. She said that she meant to go back and tell the nurse later about the resident's pain, but it had slipped her mind. Review of the Medication Administration Record [REDACTED]. A follow up interview was conducted with the resident's nurse (staff #110) on (MONTH) 2, 2019 at 1:08 p.m. She said that she normally tries to respond to a resident's request for pain medication within 15 minutes. She said sometimes she has to finish preparing and administering medication for another resident before she can respond to a resident's request, but it usually does not take more than 15 minutes. She said pain management was a top priority. An interview was conducted with the Director of Nursing (DON/staff #171) on (MONTH) 3, 2019 at 8:49 a.m. She said when a resident reports pain to staff, her expectation is that staff notify the nurse and the nurse addresses the pain as quickly as possible. She said if the nurse was preparing medications for another resident, the nurse should finish administering the medications before preparing pain medications for another resident, in order to avoid errors.

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F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) -Resident #397 was admitted on [DATE] with [DIAGNOSES REDACTED]. According to a Pain Management Review dated 9/29/19, the resident was interviewable and stated that she had pain now, and experienced pain daily or several times a day, and had back pain, neck pain and pain related to recent femur surgery. Per the assessment, the resident described the pain as aching/sharp and that physical activity and turning and repositioning made the pain worse. Non drug approaches included that cold packs helped to relieve pain and medication used in the past was [MEDICATION NAME], and that her pain had been managed well over the last three months. A care plan dated 9/29/19 revealed the resident has acute/chronic pain. The goal included to voice a level of comfort through the review date. Interventions included the resident was able to call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced and tell you what increases or alleviates pain. The interventions also included to monitor pain characteristics, severity, location, onset, duration, aggravating factors and relieving factors, monitor/record/report to nurse any signs/symptoms of non-verbal pain, pain assessment every shift and to reposition for comfort. Review of the physician's orders [REDACTED]. Review of the (MONTH) 2019 Medication Administration Record [REDACTED]. For each administration, the documentation included that the medication was effective. An interview was conducted with resident #397 on 9/30/19 at 11:30 a.m. The resident stated that her pain was not being controlled since admission. The resident stated they were giving her pain medicine, but it was not helping. The resident stated she told the nurses and they told her that she would have to wait for the physician to come in for different pain medication. Further review of the (MONTH) 2019 MAR indicated [REDACTED]. There was no clinical record documentation that the physician/nurse practitioner had been called regarding the resident's ongoing pain. According to the (MONTH) 2019 MAR, the resident was given [MEDICATION NAME]/[MEDICATION NAME] 7.5-325 mg, two tablets at 1 a.m. for a pain level of 5 and at 5:03 a.m. for a pain level of 5. Another interview with resident #397 was conducted on 10/1/19 at 10:00 a.m. and she stated that her physician had come in to see her and was changing the pain medication. Review of the physician orders [REDACTED]. An interview with a licensed practical nurse (LPN/staff #69) was conducted on 10/2/19 at 11:17 a.m. Staff #69 said when the nurses call the physicians on-call in the evening, they will not change the pain medication orders and are told to wait until the regular physician sees the resident. She stated not everyone documents that in the record. During an interview with a LPN (staff #34) on 10/3/19 at 9:15 a.m., he stated that he has called physicians and they don't want to change the pain medication and have been told to wait until the attending physician comes in to see the resident. He said they tell the residents that they must wait for their physician to see them. An interview with the Director of Nursing (DON/staff #171) was conducted on 10/3/19 at 9:33 a.m. Staff #171 stated her expectation is that if a resident's pain medication is not effective, the resident's physician should be called. Staff #171 said if the physician does not change the medication or respond to the information that the medication was ineffective, the nurse should call her and she will call the Medical Director. Staff #171 said that she expects the nurses to document calls to the physicians. Staff #171 stated that she had no information regarding resident #397's pain medication not being effective. Another interview was conducted with resident #397 on 10/3/19 at 9:57 a.m. The resident was lying in bed with two ice packs on both of her knees, as she said she was having pain. The resident confirmed that on 9/30/19 she was in pain and the pain medication was ineffective and that she was told by the nurses that she would have to wait until her physician came in to see her regarding a change in pain medication. A review of the facility's Pain Management policy and procedure revised in (MONTH) (YEAR) revealed to provide an environment and programs that assist each resident to maintain their highest practicable physical, mental and psychosocial well being. Residents are provided and receive the care and services needed according to established practice guidelines. Resident's pain is assessed and managed by an interdisciplinary team who work together to achieve the highest practicable outcome. Further the policy included to consult physician for additional interventions if pain is not relieved by currently ordered treatment modalities and comfort measures.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** Based on review of facility documentation, staff interviews and manufacturer's recommendations, the facility failed to ensure corrective action was implemented after performing a control solution test on one blood glucose monitor, when the results were outside of the recommended ranges. The deficient practice could result in inaccurate blood glucose readings. Findings include: Review of the Quality Control Record for (MONTH) 2019 for the glucometer on the 200 hall revealed sections to document that the glucometer was tested daily. This form included sections to document the normal control range and the test result and the high control range and the test result. Further review of this form revealed the control solution test for the glucometer was done on (MONTH) 2. The normal control range on the Control Record was 85-106 milligrams per deciliter (mg/dL). However, the result of the normal control test was documented at 134 mg/dL, which was outside of the normal control range. There was no evidence of any corrective action which was taken as a result of the control solution test result being outside of the normal parameters. According to the directions on the control solution bottle, the normal control range was 85-106 mg/dl. Review of the Medication Administration Record [REDACTED]. An interview was conducted on (MONTH) 2, 2019 at 10:42 a.m. with the 200 hall nurse (Licensed Practical Nurse/staff #141). She stated the blood glucose monitor control testing is completed by the night shift nurses. She stated that she had taken the blood sugars of eight residents that morning. An interview was conducted on (MONTH) 3, 2019 at 8:33 a.m., with the Director of Nursing (DON/staff #171). She stated that she expects the nurses to perform the control solution test on the blood glucose monitors correctly and make sure they are in the normal range. The DON said if the glucose monitor results are not in range, the nurses are expected to retest the monitor and discard it if it is still malfunctioning. Review of the manufacturer's user instruction manual for performing a control solution test revealed the control range should fall between the guidelines on the control solution bottle. The policy included that the monitor should not be used if the control solution result is out of range.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observations, staff interview and policy review, the facility failed to implement infection control procedures for the handling of clean and soiled clothing and linens. The deficient practice could result in the spread of infection. Findings include: An observation was conducted on (MONTH) 3, 2019 at 8:25 a.m., of the facility's laundry services. At this time, a laundry staff member (staff #84) was in the clean laundry area. In the clean laundry area was a cart which was piled with clean resident clothing. On top of the clean resident clothing was staff #84's lunch bag and a paper plate with a wrapped burrito. Staff #84 was observed transferring the burrito from the paper plate into her lunch bag and then put the lunch bag on a shelf by the wall. Staff #84 stated that the pile of laundry that she had her food on was clean laundry and she shouldn't have food on top of the clean laundry. During another observation conducted on (MONTH) 3, 2019 at 9:14 a.m., staff #84 was observed with gloves on and had on a cotton patient gown with sleeves that came above her elbows. Staff #84 then pulled a red isolation bin to the washing machine and took a yellow bag out and placed it in the washer. She then tore the yellow bag open and removed all of the

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) soiled clothing and linens. During this process, her arms were exposed from the elbows to her wrists and they were touching the soiled laundry. After this, staff #84 proceeded to untie her gown with the dirty gloves on. As she was trying to untie the gown, she touched the back of her neck and her clothing with the dirty gloves. Once the gown was untied, she removed it and put it in the washer and then removed the dirty gloves and washed her hands. Staff #84 stated that her arms above the wrist were touching the dirty isolation laundry and that dirty isolation laundry should always be handled with gloves and should not be touching bare skin. An interview was conducted on (MONTH) 3, 2019, at 10:35 a.m. with the Director of Nursing (DON/ staff #171), who stated the laundry staff member should have been wearing a yellow gown that has full sleeves when sorting and loading the dirty laundry, so that the dirty clothes are not touching the skin. Review of a policy titled, Infection Prevention and Control Program revealed to implement infection control measures to prevent the spread of communicable diseases and conditions. Standard precautions including contact precautions include putting gloves on immediately before anticipated contact with non-intact skin or blood and other body fluids or when touching surfaces soiled with blood or other body fluids. Remove gloves when the specific task is completed and wash hands immediately. The policy also stated to wear gowns when it is anticipated that there would be contact with blood or other body fluids or soiled surfaces. For linens, the policy stated that all contaminated linens should be handled appropriately whether their source was an isolation room or non-isolation room. All linens should be handled as if it were highly infectious. Healthcare workers play an important role in reducing the potential for transmission of infectious microorganisms.